General Assembly

Raised Bill No. 6461

January Session, 2013

LCO No. **3443**

Referred to Committee on AGING

Introduced by:
(AGE)

AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-342 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection **[**(i)**]** (j) of this section. For purposes of this section, a long-term care facility is a facility which has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The annualized cost of the community-based services provided to such persons under the program shall not

exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities. The program shall be structured so that the net cost to the state for long-term facility care in combination with the community-based services under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or supplemental nutrition assistance program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has mental retardation shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

(b) The commissioner shall solicit bids through a competitive

process and shall contract with an access agency, approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection **[**(e)**]** (n) of this section, that submits proposals which meet or exceed the minimum bid requirements. In addition to such contracts, the commissioner may use department staff to provide screening, coordination, assessment and monitoring functions for the program.

(c) The community-based services covered under the program shall include, but not be limited to, the following services to the extent that they are not available under the state Medicaid plan, occupational therapy, homemaker services, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state-funded congregate housing and in other assisted living pilot or demonstration projects established under state law. Personal care assistance services shall be covered under the program to the extent that (1) such services are not available under the Medicaid state plan and are more cost effective on an individual client basis than existing services covered under such plan, and (2) the provision of such services is approved by the federal government. Recipients of state-funded services pursuant to subsection (j) of this section and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending and are determined presumptively eligible for Medicaid pursuant to subsection (e) of this section, shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.

(d) Physicians, hospitals, long-term care facilities and other licensed health care facilities may disclose, and, as a condition of eligibility for

the program, elderly persons, their guardians, and relatives shall disclose, upon request from the Department of Social Services, such financial, social and medical information as may be necessary to enable the department or any agency administering the program on behalf of the department to provide services under the program. Long-term care facilities shall supply the Department of Social Services with the names and addresses of all applicants for admission. Any information provided pursuant to this subsection shall be confidential and shall not be disclosed by the department or administering agency.

[(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to define "access agency", to implement and administer the program, to establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process and to specify conditions of eligibility.**]**

(e) Not later than October 1, 2013, the Commissioner of Social Services, in consultation with the Commissioner on Aging, shall establish a system under which the state will fund services under the Connecticut home-care program for the elderly for a period of up to ninety days for applicants who require a skilled level of nursing care and who are determined to be presumptively eligible for Medicaid coverage. Such system shall include, but not be limited to: (1) The development of a preliminary screening tool to be used by representatives of the access agency selected pursuant to subsection (b) of this section to determine whether an applicant is functionally able to live at home or in a community setting and is likely to be financially eligible for Medicaid; (2) authorization by the Commissioner of Social Services for such access agency representatives to initiate home-care services not later than five days after such functional eligibility determination for applicants deemed likely to be eligible for Medicaid; (3) a presumptive financial Medicaid eligibility determination for such applicants by the Department of Social Services not later than seventy-two hours after the functional eligibility determination; and (4) a written agreement to be signed by such applicant attesting to the

accuracy of financial and other information such applicant provides and acknowledging that (A) state-funded services shall be provided not later than ninety days from the date on which the applicant applies for Medicaid coverage, and (B) such applicant shall complete a Medicaid application on the date such applicant is screened for functional eligibility or not later than ten days from such screening. The Department of Social Services shall make a final determination as to Medicaid eligibility for presumptive eligibility applicants not later than forty-five days after receipt of a completed Medicaid application from such applicant.

(f) Pursuant to section 1560.10 of the Department of Social Services' uniform policy manual, the Commissioner of Social Services shall retroactively apply a final determination of Medicaid eligibility for presumptive Medicaid eligibility applicants. The commissioner shall request available federal matching Medicaid funds for state costs during the ninety-day presumptive Medicaid eligibility period for applicants determined to be eligible for Medicaid coverage. The commissioner, in consultation with the Commissioner on Aging, shall identify funding pursuant to the federal Older Americans Act of 1965, as amended from time to time, that may be allocated to subsidize costs during the presumptive eligibility period for those applicants who are not determined eligible for Medicaid. State costs during the presumptive eligibility period shall be offset by available federal Medicaid reimbursements and savings realized for institutional care that would have been necessary but for the presumptive eligibility system.

[(f)**]** (g) The commissioner may require long-term care facilities to inform applicants for admission **[**of the**]** to the Connecticut home-care program for the elderly established under this section and to distribute such forms as the commissioner prescribes for the program. Such forms shall be supplied by and be returnable to the department.

[(g)**]** (h) The commissioner shall report annually, by June first, in

accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the Connecticut home-care program for the elderly in such detail, depth and scope as said committee requires to evaluate the effect of the program on the state and program participants. Such report shall include information on (1) the number of persons diverted from placement in a long-term care facility as a result of the program, (2) the number of persons screened, (3) the average cost per person in the program, (4) the administration costs, (5) the estimated savings, and (6) a comparison between costs under the different contracts.

[(h)**]** (i) An individual who is otherwise eligible for services pursuant to this section shall, as a condition of participation in the program, apply for medical assistance benefits pursuant to section 17b-260 when requested to do so by the department and shall accept such benefits if determined eligible.

[(i)**]** (j) (1) On and after July 1, 1992, the Commissioner of Social Services shall, within available appropriations, administer a state-funded portion of the Connecticut home-care program for the elderly for persons (A) who are sixty-five years of age and older and who are not eligible for Medicaid; (B) who are inappropriately institutionalized or at risk of inappropriate institutionalization; (C) whose income is less than or equal to the amount allowed under subdivision (3) of subsection (a) of this section; and (D) whose assets, if single, do not exceed the minimum community spouse protected amount pursuant to **[**Section**]** section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed one hundred fifty per cent of said community spouse protected amount and on and after April 1, 2007, whose assets, if single, do not exceed one hundred fifty per cent of the minimum community spouse protected amount pursuant to **[**Section**]** section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed two hundred per cent of said community spouse protected amount.

(2) Except for persons residing in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e, as provided in subdivision (3) of this subsection, any person whose income is at or below two hundred per cent of the federal poverty level and who is ineligible for Medicaid shall contribute seven per cent of the cost of his or her care. Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute seven per cent of the cost of his or her care in addition to the amount of applied income determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of the general statutes, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(3) Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income is at or below two hundred per cent of the federal poverty level, shall not be required to contribute to the cost of care. Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income exceeds two hundred per cent of the federal poverty level, shall contribute to the applied income amount determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person whose income exceeds two hundred per cent of the federal poverty level and who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of the general statutes, the department shall not be required to provide an administrative hearing to a person found ineligible for services under

this subsection because of a failure to contribute to the cost of care.

(4) The annualized cost of services provided to an individual under the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such amount under the Department of Social Services in the fiscal year ending June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual to exceed the maximum cost established pursuant to this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

[(j)**]** (k) The Commissioner of Social Services may implement revised criteria for the operation of the program while in the process of adopting such criteria in regulation form, provided the commissioner prints notice of intention to adopt the regulations in the Connecticut Law Journal within twenty days of implementing the policy. Such criteria shall be valid until the time final regulations are effective.

[(k)**]** (l) The commissioner shall notify any access agency or area agency on aging that administers the program when the department sends a redetermination of eligibility form to an individual who is a client of such agency.

[(l)**]** (m) In determining eligibility for the program described in this section, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran.

(n) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to (1) define "access agency", (2) implement and administer the program, (3) implement and administer

the presumptive Medicaid eligibility system, (4) establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process, and (5) specify conditions of eligibility.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2013*	17b-342

Statement of Purpose:

To save state funds on institutionalization by establishing a presumptive eligibility program for home care.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]